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# The History of Confidentiality in Medicine: The Physician-Patient Relationship

## SUMMARY

The author of this article reviews the history of the confidentiality of medical information relating to patients from its roots in the Hippocratic Oath to the current codes of medical ethics. There has been an important shift in the basis for the demand for confidentiality, from a physician-based commitment to a professional ideal that will improve the physician-patient relationship and thus the physician's therapeutic effectiveness, and replace it with a patient-based right arising from individual autonomy instead of a Hippocratic paternalistic privilege. (*Can Fam Physician* 1989; 35:921-926, 914.)

## RÉSUMÉ

L'auteur de cet article passe en revue l'histoire de la confidentialité des dossiers médicaux à partir du serment d'Hippocrate aux codes actuels définis par l'éthique médicale. On constate une évolution importante au niveau des fondations mêmes des demandes de confidentialité, à partir d'une obligation reposant sur le médecin à un idéal professionnel, lequel améliorera la relation médecin-patient et, en conséquence, l'efficacité thérapeutique du médecin et remplacera le privilège paternaliste d'Hippocrate par un droit du patient tel que défini par l'autonomie individuelle.

**Key words:** ethics, medical, confidentiality, physician-patient relationship

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**C**ONFIDENTIALITY of medical information is so important to the doctor-patient relationship that it is now regarded as the norm for physicians. Thus a 20th-century novelist can describe a physician as follows:

His face...was moulded in a great strength and confidence; the eyes were deep and wise; the mouth closed firmly as if on the Oath of Hippocrates — the seal of silence and the knowledge of discretion.<sup>1</sup>

The Oath, thought to be a fragment of the ritual of the Pythagorean brotherhood, dating to between the 6th and 3rd centuries B.C., is probably the oldest part of the Hippocratic collection of writings.<sup>2,3</sup> The initiate was required to swear:

And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.<sup>4</sup>

This oath places an absolute duty on the physician not only to preserve the confidentiality of medical information, but also to observe discretion about general information relating to patients to which they may become privy in social intercourse. This duty arose from the fact that the physician, although by then an itinerant craftsman, a guild member with a distinct body of knowledge and skills,<sup>3</sup> still possessed some elements of the role of priest or exorcist. Secrets were still considered sacred, whence the further commitment that "Pure and holy I will keep both my life and art."

Hippocrates, under the heading "Decorum" also warned that the physician must "say only what is absolutely necessary. For he realizes that gossip may cause criticism of his treatment,"<sup>4</sup> believing that such criti-

cism would undermine a patient's confidence in his physician and thus in the prescribed treatment.

However, the Oath limits the physician's secrecy to that "which should not be published abroad", without defining what is so prohibited. The decision as to what is to be kept secret is left to the physician's discretion within the bounds of social or professional convention. In addition, the Oath instructs physicians to use treatment according to their "ability and judgement, but never with a view to injury or wrongdoing."<sup>4</sup> Throughout the centuries this directive has been understood by physicians to mean that when, in the physician's professional opinion, disclosure of confidential information is in the patient's best interest, then he may act on his conviction without violating the Oath.

## The Western Tradition of Confidentiality

The requirement for physicians to maintain professional secrecy seems to have been well known in the later Roman Empire, for in the 4th centu-

ry, St. Jerome quoted from it in his reply to Nepotian's request for advice about a cleric's duties:

It is part of your (clerical) duty to visit the sick...Hippocrates, before he will instruct his pupils, makes them to take an oath and compels them to swear obedience to him. That oath extracts from them silence, and prescribes for them their language, gait, dress and manners. How much greater an obligation is laid on us (clergymen)...<sup>5</sup>

In the Middle Ages, the Hippocratic Oath was held in high esteem,<sup>6</sup> although modified to make it acceptable to Christians, it reminded physicians of their duty to maintain the secrecy of information about the patient and to avoid gossip.<sup>7</sup> Constantine the African (c. 1010–87 A.D.) noted that the physician "ought to keep to himself confidential information concerning the ailment, for at times the patient makes known to the physician things he would blush to tell his parent."<sup>8</sup> Some qualified the demand for secrecy as in an 11th century manuscript: "unless it be something that ought to be reported or judged."<sup>9</sup>

Other still surviving documents<sup>4</sup> stress decorum and conduct. In his treatise on "Fistula-in-Ano", in about 1370, John Aderne wrote of the physician's necessity for discretion in manner, dress and speech, as well as professional secrecy — "for if a man sees that you hold secret another's information, he will better trust you" — to further the patient's confidence in his surgeon. Similarly, a 15th century French manuscript states that a physician "ought not to be a deceiver. Like a friend he should maintain silence."<sup>10</sup>

Of our versions extant in 16th century England, the earliest seems to be that of John Securius. In *A Detection and Querimonie of the daily enormities and abuses committed in physic*, published in London in 1566, his version of the demand for professional secrecy<sup>5</sup> is as follows:

And whatsoever I shal see or heare among my cures (yea although I be not sought nor called to any) whatsoever I shal know among the people, if it be not laudful to be uttered, I shal kepe close...secrete unto my selfe.

John Gregory (1724–73), Professor of Medicine at Edinburgh University, in *Lectures on the Duties and Qualifications of a Physician*, reminded physicians<sup>9</sup> that they had "many opportunities of knowing the private characters and concerns of the families" in which they were employed. They saw "people in the most disadvantageous circumstances, very different from those in which the world views them." He commented that the "characters of individuals and the credit of families may sometimes depend on the discretion...of the physician. Secrecy is particularly requisite where women are concerned..."

The admonition to preserve decorum and discretion of speech was continued by emigrants to North America. Thus, in the United States, Samuel Bard (1742–1821) warned particularly "Do not raise your fame on the Ruins of another's Reputation..."<sup>14</sup>

The requirement for professional secrecy has also been present for centuries in other traditions of medicine, such as the Indian traditional medicine *Charaka-Samhita*, which dates from about 100 A.D.,<sup>7</sup> and the Jewish Oath of Asaph, which dates from the 2nd to 7th centuries.<sup>10</sup>

### A Consistent "Hippocratic" Exception to Confidentiality

No matter how stringently a physician regarded "professional secrecy", there was one area in which physicians would exercise their Hippocratic privilege: namely, to conceal from a patient with incurable disease the fatal nature of the illness, but disclose it fully and freely to the family and close friends. This was customary in Britain (but less so in North America) until the last two or three decades. The attitude is well described in C.P. Snow's novel, *The Masters*. The Master of the college has been found to have inoperable carcinoma of the stomach; his wife and daughter have been so informed. Now members of the Senior Common Room are talking:

"Yes, we've heard his sentence," said Jago. "But there is one last thing which seems to me more ghastly than the rest. For there is someone who has not heard it... that is the man himself. They are not going to tell him yet...For

some reason that seems utterly inhuman, these doctors have not told him. He's been given to understand that in two or three months he will be perfectly well. When any of us see him, we are not to let him know any different."<sup>11</sup>

The tradition of uncommunicativeness by physicians is foreshadowed by Cassiodorus (480–575 A.D.), who wrote in a letter: "To make things easier, do not tell the clamouring enquirer what the symptoms signify."<sup>5</sup> Similarly, an Italian surgeon of pre-Renaissance times, Guglielmo Salicet, (c. 1210–77) commanded gentleness, adding:

...promise them cure in all cases, even though they are hopeless ...But, it is necessary that the doctor discuss the condition of the illness with the friends or relatives of the patient...lest the friends might not find themselves prepared against all cruel disillusion, and so that, if the patient should die, one could not say that the doctor has caused his death, but speak well of his recovery, if the patient is cured."<sup>12</sup>

A similar instruction was given by Lanfranc (Guido Lanfranchi of Milan, died c. 1306), one of Salicet's pupils, who moved to Paris in 1295, and was later acknowledged the founder of surgery in France,<sup>12</sup> and by Hieronymus Brunschwig (c. 1450–1512), a 15th century German surgeon.<sup>12</sup>

Some practitioners even went so far as to warn physicians to keep away from patients they believed were fatally ill. Thus, MacKinney, in his essay on medical ethics in the Middle Ages, recorded eleven manuscripts of the 9th to 15th centuries, containing popular treatises on monastic medical practice that advise physicians: "Never become knowingly involved with any who are about to die or who are incurable."<sup>15</sup>

Opinions were beginning to divide in the late 18th century. In the United States, perhaps reflecting the new ethics of responsibility for oneself in a society that separated many from their family supports, Benjamin Rush (1745–1813), outstanding physician-educator and humanist, strongly deprecated falsehoods told or implied by physicians: "Criminal is the practice of some physicians of encourag-

ing patients to expect a recovery in diseases which have arrived at their incurable stage."<sup>13</sup>

In Scotland, however, John Gregory, his contemporary, expressed ambivalence about the issue, stating that:

A deviation from truth is sometimes in this case both justifiable and necessary. It often happens that a person is extremely ill: but may yet recover, if he is not informed of his condition. It sometimes happens on the other hand, that a man is seized with a dangerous illness, who has made no settlement of his affairs: and yet the future happiness of his family may depend on his making such a settlement...But, in every case, it behoves a physician never to conceal the real situation of the patient from his relatives.<sup>9</sup>

## Modern Codes of Ethics

What has been called "the first modern ethical code of medical ethics" was published in 1803 by Thomas Percival (1740–1804) of Manchester, England. Its publication was occasioned by an outbreak of typhus fever that severely taxed the physicians of the Manchester Royal Infirmary. Recognizing this, the Board of Governors appointed more physicians to assist them, but without consulting them, which led to sharp conflict with the existing medical staff. Percival's colleagues asked him to prepare a guide to physicians' conduct. His book, *Medical Ethics*,<sup>14</sup> contained four sections concerning medical conduct in hospitals; private or general practice; relations with apothecaries; and those professional duties that required a knowledge of the law. Percival mentions confidentiality twice; he first remarks:

In the large wards of an Infirmary the patients should be interrogated concerning their complaints, in a tone of voice which cannot be overheard. Secrecy, also, when required...should be strictly observed. (*Ch. 2, Sect. I*)

The second reference relates to the duties and responsibilities of the physician in private or general practice:

Secrecy, and delicacy when required by peculiar circumstances should be strictly observed. And

the familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honour. (*Ch. 2, Sect. I*)

He also expressed concern over the relationships among physicians:

No physician or surgeon, therefore, should reveal occurrences in the hospital, which may injure the reputation of any one of his colleagues. (*Ch. 1, Sect. IX*)

This, to our modern ears, smacks of the "guild" concept of the profession. It must be remembered, however, that the modern concept of a unified profession, self-governing by delegated authority from a legislative Act, did not exist. In the United Kingdom health care was practised by three widely disparate groups: physicians, surgeons, and apothecaries. Members of these groups were diverse in their social standing and class, education, and training, as well as in the division of their professional responsibility. The rest of the book is pervaded by the paternalistic attitudes of professionals, reflecting more the social attitudes and values of the period than its medical practice. In many ways Percival's "ethical" physician is the cultured English gentleman of "the Enlightenment."

The value of Percival's work was readily perceived and approved by physicians such as William Heberden, the elder (1710–1803),<sup>14</sup> and in the United States it became the basis of the first American Medical Association's code of ethics, adopted in 1846.<sup>4</sup>

In 1948, in its Declaration of Geneva, the World Medical Association (WMA) simply stated,<sup>4</sup> "I will respect the secrets confided in me." In its explanation of the code, however, the statement went further and declared:

A doctor owes to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.

This is an absolute duty owed only to the patient: the Declaration does not recognize any obligation to society by the physician; it reflects the traditional dyadic relation of physician and patient. In contrast to its ancient prede-

cessor, however, it provides no casuistic Hippocratic exception to its demand for secrecy.

## Legal Aspects of Professional Confidentiality

Although physicians regard professional secrecy as a clear duty and realize that the failure to observe it may lead to some form of professional sanction, the question has arisen whether the law regards this duty as absolute. Is the communication between physician and patient invariably regarded as privileged to the extent that the physician cannot be compelled to give evidence in court?

In Canada communications between physician and patient are not privileged: the physician may be compelled to be a witness. This was succinctly stated by Lord Mansfield in 1776, in the bigamy trial of the Duchess of Kingston. When the physician called as a witness asked whether information derived from his professional duty should be disclosed, Mansfield stated:

If a surgeon was to voluntarily reveal these secrets, to be sure he would be guilty of a breach of honour, and a great indiscretion: but to give that information in a court of justice which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatsoever.<sup>15</sup>

In addition, there are statutory obligations that require physicians to break the confidentiality of medical communication. These obligations derived initially from the need for accurate data relating to vital statistics, in particular from the notification of births and stillbirths, and the certification of death. Later, statutes were passed making communicable diseases and venereal disease notifiable.

In Quebec, British Columbia, and Ontario, a physician must disclose the name of a patient he believes is unfit to drive a motor vehicle; in Alberta, physicians are encouraged to do so,<sup>15</sup> and are granted protection as part of the statute. The most recent enactment bearing the statutory obligation to disclose confidential medical information is the *Aeronautics Act*, 1985. The possible effects of the *Act* were forcibly stated by the then President of the Canadian Medical

Association, Dr. T.A. MacPherson, who asserted:

It invades the privacy of pilots and the doctor/patient relationship, vitiates the doctor/patient contract, forces pilots to practise self-incrimination and forces physicians to break the law and medical ethics related to the confidentiality of medical records.<sup>16</sup>

## Patients' Rights and Confidentiality

The language of natural rights began with John Locke (1632–1704), who held<sup>17</sup> that men are in:

...a state of perfect freedom to order their actions, and dispose of their possessions and persons as they think fit within the bounds of the Law of Nature, without asking leave, or depending upon the will of any other man.

Furthermore, a man

...ought as much as he can to preserve the rest of mankind and may not, unless it be to do justice to an offender, take away the life, liberty, health, limb or goods of another.

An obvious extension of such autonomy is the patient's right to confidentiality, with the correlative duty on the part of the physician to preserve secrecy.

The ground for the physicians' preservation of confidentiality of medical information has thus been shifted from a physician-based commitment to a professional ideal (a concept that will promote the physician-patient relationship and enhance the former's therapeutic role) to a patient-based right whereby the physician has the duty of secrecy to his patient. On the former ground, a Hippocratic view of confidentiality could be taken: if, in the physician's professional judgement, it was in the patient's best interest in some special circumstance to divulge information, then confidentiality could be broken with perfect propriety. However, no Hippocratic privilege exists on the latter ground, that of the rights of the patient and the correlative duty of the physician. The obligation of secrecy owed to the patient is absolute, although the law may require it to be breached in the interests of society.

The explanation of such an impor-

tant change in the basis of confidentiality of information lay precisely in that Hippocratic privilege by which the physician's professional judgement of what he deemed to be in the patient's best interest, could override his commitment to confidentiality, without being considered any breach of the ethical code. This is a manifestation of paternalism based on the assumption that the physician knows best.

As the Hippocratic privilege of exception arising from professional judgement of the patient's interest has been eroded and replaced by the language of natural right and absolute obligation, the statutory and administrative requirements for disclosure of confidential medical information have risen steadily. Englehardt argues trenchantly for absolute confidentiality, declaring that "the principle of autonomy makes it morally permissible to create such special exclaves secure against such requirements or disclosure."<sup>18</sup> He concedes that there is an instrumental value to professional confidentiality however, for he says:

...there may be special advantages from both priests and physicians offering strict confidentiality. The capacity of priests and physicians to function in their special roles, which have social value, may be undercut by the notion that compelling State interests could force disclosure of their private communications.<sup>18</sup>

Kottow argues vigorously that professional medical confidentiality is an intransigent and absolute obligation: strong words indeed. His reason for adopting this position is to be found, not in duties arising from the autonomy of the patient, but from the instrumental value of confidentiality to the physician-patient relationship.<sup>19</sup>

In the past, much of the impetus for statutory disclosure of information has arisen from public apprehension over diseases such as cholera, syphilis, tuberculosis, scarlet fever, and poliomyelitis. If the individual's natural right to confidentiality can be overridden by the societal right to know, it is not too difficult to imagine that in times of public anxiety about diseases such as AIDS,<sup>20</sup> there will be demands for increased disclosure of personal medical information. The

physician will find it difficult to refuse these demands because the basis of his ethical code has changed. In short, the benign paternalism of a personal physician has been abandoned for the compulsory paternalism of a faceless State.

## Examples of Hippocratic Professional Judgement

Two cases illustrate how a physician may behave paternalistically, breaking confidentiality on the grounds of acting in the patient's best interest as determined by the physician's professional judgement.

The first example is that of a physician who published details of his patient's medical history.<sup>21</sup> Lord Moran was a distinguished British physician, President of the Royal College of Physicians, Dean of St. Mary's Hospital Medical School, and personal physician to Sir Winston Churchill from May 1940 until Churchill's death in 1965. According to his custom, he kept a diary, recording notes of conversations with the Prime Minister. He was encouraged to publish these notes by several distinguished people, including the politician Brendon Bracken, the statesman Jan Smuts, and the historian G.M. Trevelyan.<sup>21</sup> He wrote in the preface to his book:

I was shaken by Trevelyan's insistence that a knowledge of these particular facts might disarm criticism of Winston's conduct of affairs in the last year of the war and that if I did not record them, no one else could. It was surely not fair to Winston to withhold these extenuating circumstances. But so deeply ingrained in my mind was a binding obligation to preserve a decent reticence after seeing patients that I was still reluctant to try to write about Winston while I was his doctor.<sup>21</sup>

Moran's justification for breaking professional secrecy was that it would elicit sympathy and understanding for his patient who had died a year before the book was published. It clearly could not improve the physician-patient relationship, for that had been broken "by the stranger who cannot be denied," but it would enhance the reputation of a man already illustrious. Moran wrote:

It is not possible to follow the last

twenty-five years of Winston's life without a knowledge of his medical background. It was exhaustion of mind and body that accounts for much that is otherwise inexplicable in the last year of the war — for instance, the deterioration in his relations with Roosevelt...It is certain that the onset of old age and the succession of strokes explain in part why he was not more effective as Leader of the Opposition, and later as First Minister of the Crown.<sup>21</sup>

One may ask why did not Moran's duty to the British public, as well as to his patient, ensure that an ill, deteriorating man, no matter how illustrious, lay down the seals of office much earlier? The answer is in the Hippocratic concepts that influenced Moran's professional behaviour: namely, the personal commitment solely to the patient, and the duty of professional secrecy to be broken only if, in his professional judgement, it was in the patient's best interest. Lord Moran did not escape censure by his colleagues. An editorial in the *British Medical Journal* stated:

At a time when both the State and public curiosity obtrude more and more upon the privacy of the citizen, most doctors would be unwilling to countenance any loosening of traditional reticence about things seen or heard in the course of medical practice. It would be most unfortunate if Lord Moran's book led the public to think otherwise.

Similarly, *Lancet* editorialized:

A doctor, like a lawyer or priest, does not readily recount his professional dealings with an identifiable person; and the public's trust in the medical profession derives largely from its conviction that what transpires between doctor and patient will not be bandied about. If this confidentiality is owed to the living, it is doubly owed to the dead. Sir Winston may have agreed to the diaries appearing after his death. But that is beside the point. The point is that Lord Moran, by writing publicly about the medical condition of an identified patient is creating a modern precedent. It is a bad

precedent which none should follow.<sup>23</sup>

Ordinary members of the profession also expressed their concern:

It would appear to me to have published even a historically important document of this type is a gross contravention of one of the first rules of medical ethics by a senior member of the profession.

A second example of the use of Hippocratic professional judgement to breach a patient's confidence ethically is well illustrated by the case of Dr. Robert Browne who, in 1971, appeared before a disciplinary hearing of the General Medical Council of the United Kingdom to answer a charge of serious professional misconduct.<sup>25</sup> His patient, a 16-year-old girl, had attended the Brooke Centre, a family planning clinic, where an oral contraceptive was prescribed. She gave her consent for her family physician, Dr. Robert Browne, to be notified. His concerns were:

...in two areas, the possible psychological hazards if the girl was keeping a guilty secret, with possible adverse emotional impact and, secondly, the risk of placing her on a dangerous drug...and steroids were a particular hazard.<sup>25</sup>

Dr. Browne had been the family physician for many years and knew that the girl's parents were the best people to counsel her in their own way; they were sympathetic and kindly, and could handle the situation with care and tact. After consultation with colleagues, preserving anonymity, he informed the parents. Subsequently, the family planning clinic reported Dr. Browne to the General Medical Council for serious professional misconduct in telling the girl's parents that she was receiving oral contraceptives.

In cross-examination, "Dr. Browne said his interests were primarily for the patient and for her alone. He had no other interest except what was best for her."<sup>25</sup>

Among the expert witnesses called for the defence were several distinguished physicians, including family physicians with long experience. One, a general practitioner of 38 years experience, and a past Chairman of the Central Ethical Commit-

tee of the British Medical Association said that:

In his view a third party could not fetter the right of the doctor — for instance, by a letter such as the one from the Brooke Centre — to exercise his own judgement.<sup>25</sup>

Another highly respected female practitioner of 38 years experience said that:

In her view professional secrecy existed in the interest of the patient. She considered that there could be situations in which the benefit of the patient meant that a confidence must be disclosed. Every case should be judged on its own merit by the practitioner involved.<sup>25</sup>

After hearing similar evidence from other practitioners, the Council found that Dr. Browne was not guilty of serious professional misconduct.

Following this case the British Medical Association's Code of Ethics of 1959 was changed. The code had stated:

It is a practitioner's obligation to observe the rule of professional secrecy by refraining from describing voluntarily without the consent of the patient (save with statutory sanction) to any third party, information which he has learnt in his professional relationship with the patient. The complications of modern life sometimes create difficulties for the doctor in the application of this principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding considerations must be adoption of a line of conduct that will benefit the patient, or protect his interests.<sup>26</sup>

The revised code adopted in 1972 stated:

If in the opinion of the doctor, disclosure of information to a third party seems to be in the best medical interest of the patient, it is the doctor's duty to make every effort to allow the information to be given to the third party, but where the patient refuses, that refusal must be respected.<sup>26</sup>

## Current Situation in Canada

In Canada the absolutist view of

confidentiality based on patient autonomy does not apply because physicians have statutory obligations to disclose confidential information. The current Code of Ethics of the Canadian Medical Association (CMA), adopted in 1984, states<sup>27</sup> as its fourth core principle, "Protect the patient's secrets." In paragraph six of the section describing "Responsibilities to the Patient", the limitations on the physician's duty of confidentiality are defined:

The physician will keep in confidence information derived from his patient, or from a colleague and divulge it only with the permission of the patient except when the law requires him to do so.<sup>27</sup>

It is clear that there is no possibility given to the physician to exercise the right of Hippocratic judgement, although the CMA Code does not subscribe to the absolutist position of the WMA Code, in that it places societal rights above those of the individual patient. This is in contrast to the American Medical Association Code of Ethics, which preserves the Hippocratic exception, stating that:

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of his patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the society.<sup>26</sup>

Despite these regulations, however, the vestige of the Hippocratic exception still appears in modern practice. Thus, the College of Physicians and Surgeons of Alberta, after quoting the statement on confidentiality from the CMA Code of Ethics, and stating that it fully supports this as a guide, passed the resolution:

Also be it resolved that where a physician has reasonable knowledge from his professional attendance upon a patient that a crime may be, or may have been committed, such physician shall not be considered to be in breach of medical ethics if he reveals such relevant information to the appropriate authority.<sup>27</sup>

In a further comment, the Council resolution adds that:

There are rare occasions to be

judged on an individual basis when it is not unethical to make discrete disclosures to an appropriate person, with the patient's knowledge that such disclosure is to be made, when the public interest far outweighs the interest of the patient, such as the airline pilot who has epilepsy.<sup>28</sup>

This statement only requires that the patient be informed of the physician's intention, not that his consent should be sought or given.

The general duty of discretion with regard to the profession has applied throughout the history of professional ethics. It is also stressed in the CMA Code of Ethics, in paragraph six of the section entitled "Responsibilities to the Profession", where it is stated that, "the physician is to conduct himself in such a manner as to merit the respect of the public for members of the medical profession" and to "avoid impugning the reputations of his confrères".<sup>27</sup>

The history of professional confidentiality illustrates the inevitability of conflict for the physician arising from duties owed to a particular patient, versus the competing and legitimate interests of the family and society. To resolve these conflicts in the absence of any professional ethical statement or clear legal duty, the fundamental concept to be borne in mind is that of "patient-autonomy", with the duty of "physician-beneficence" existing within that boundary. In Canada, to exercise paternalistic Hippocratic judgement is to act unethically, although there is evidence that some physicians are still prepared to do so.<sup>29</sup>

## Conclusions

The long history of secrecy relating to the information obtained in the course of a doctor-patient relationship has two fundamental features: namely, that it is a personal commitment to the patient, based on the Hippocratic Code, and secondly, that it is subject to the physician's professional judgement of what is in the patient's best interest. Circumstances have changed drastically, and both concepts have changed; in fact, the latter, the basis for physicians' paternalism, has been removed from the current Canadian professional code of ethics. Although the physician is still committed to his patient, and his

prime goal is to act in accordance with the patient's welfare, these considerations are no longer his sole objective, for the interests of society occupy an increasing share of his attention. The maintenance of strict secrecy of medical information is impossible, especially in the modern hospital, where many professionals are involved in the care of the patient and have legitimate access to such records. It is not surprising, therefore, to find Hippocratic ideals described as outmoded, outworn, decrepit, and inappropriate for the complexity of 20th century health-care delivery systems.<sup>31,32</sup> This may well be so, but their passing deserves recognition, for they have served well for two-and-a-half millennia. ■

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## References

1. Williams C. *Place of the lion*. Grand Rapids, MI: W.B. Eerdmans Publishing Co., 1976: 196.
2. Temkin O, Temkin L. *Ancient medicine: selected papers of Ludwig Edelstein*. Baltimore, MD: Johns Hopkins University Press, 1967: 16-20.
3. Carrick P. *Medical ethics in antiquity*. Dordrecht/Boston/Lancaster: D. Reidel Publishing Co., 1985: 66-86; 12.
4. Reiser SJ, Dyck AJ, Curran WJ, eds. *Ethics in medicine: historical perspectives and contemporary concerns*. Cambridge, MA: Massachusetts Institute of Technology Press, 1977: 5, 6, 12-15, 17, 26-34, 37-8.
5. Burns CR, ed. *Legacies in ethics and medicine*. New York: Science History Publications, 1977: 173-203, 175, 199, 191, 190, 218-36, 176, 195.
6. Kibre P. Hippocratic writings in the Middle Ages. *Bull Hist Med* 1945; 18:371-412.
7. Jones WHB. *Doctor's oath: the manuscripts of the Hippocratic Collection*. London, U.K.: Cambridge University Press, 1924: 10, 58-9.
8. Coulton GG. *Social life in Britain from the Conquest to the Reformation*. London, U.K.: Cambridge University Press, 1918: 496-501.
9. Gregory J. *Lectures on the duties and qualifications of a physician*, Edinburgh, Continued on page 914

structures in women,' said the specialist. To provide proper support, the seat should be one to two inches wider than the interischial distance.

Although no known data support the specialist's supposition, she expects to see a decline in the number of design-related injuries to women. Part of injury prevention is having the proper equipment, she said. It makes sense that the new designs for women's bikes could leave less room for injury because they provide a proper fit."

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## Dangers of Using Rubber Gloves

"The all-pervasive rubber glove worn to ward off irritating chemicals may not be all that fail-safe, according to a clinical professor of dermatology.

The fear of AIDS has resulted in a 400% increase in the use of rubber gloves in the United States in the past few years, he said. However, wearing rubber gloves can lead to a number of potential dermatological problems.

Because of the [risk] of [contracting] AIDS, medical and dental personnel are wearing gloves throughout an entire workday, going only short periods without them, he said. On continuous wearing, heat and moisture remain trapped on the skin. This promotes fungal growth, especially between the third and fourth fingers, where moisture and heat tend to build up.

Fungal infections also tend to grow around the nail. In either case, it means having to remain off work, often for three weeks or a month, in order for the infection to clear, the dermatologist said.

Other reactions, including contact dermatitis and contact urticaria, are also fairly common, he said, but these are usually due to the powders and other chemicals used to treat the rubber, and less to rubber itself.

If the allergen can be identified, less allergenic gloves should be used (both powderless and polyurethane-type gloves are commercially available).

However, he added, if an allergy does develop, it can be a serious problem for any health-care profes-

sional, and some people may find that they have to change occupations unless satisfactory replacement gloves can be found.

Even if rubber gloves do not in themselves cause a problem, it still cannot be said that they are effective in preventing all reactions from a number of commonly handled irritants. Plastics, solvents and nickel (notably for orthopedic surgeons, the nickel contained in hip prostheses) can all penetrate rubber gloves.

The only solution, once a handler is sensitized to the irritant or allergen, is to avoid the chemical altogether."

**Harrison P. Rubber gloves may cause problems. Ontario Medicine 1988; 7(20):17.**

## Implications For Managing Ethanol Drug Toxicity

"Lowering body temperature by manipulating ambient temperature may reduce mortality from ethanol overdose or combined ethanol and pentobarbital use, report researchers at the University of California in Los Angeles. The researchers injected mice with a potentially lethal dose of ethanol or a combination of ethanol and pentobarbital, then placed them in temperature-controlled chambers at 20°C, 25°C, 30°C, or 35°C and observed them for mortality for 24 hours. They learned that body temperature declined with decreasing ambient temperature, and that the survival rate up to eight hours increased in both the ethanol and ethanol-pentobarbital groups as body temperature decreased. These findings have possible clinical implications: Treatment protocols for ethanol or ethanol-drug overdose accompanied by life-threatening severe hypothermia call for warming the patient. In special cases where extreme hypothermia is not present but the patient is at high risk from ethanol toxicity, the findings suggest it may be possible to reduce mortality by holding body temperature constant at a subnormal level as part of the treatment."

**Macdonald DI. From the alcohol, drug abuse, and mental health administration. JAMA 1988; 259(3):3384.**

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1788. London, U.K.: A. Strahan & T. Caddell, Edinburgh: W. Creech, 1788: 37.

10. Rosner F, Muntner S. Oath of Asaph. *Ann Int Med* 1967; 41:440-54.

11. Snow CP. *Masters*. London, U.K.: MacMillan, 1959: 7.

12. Veith I. Changing concepts of health care: a historian's view. *West J Med* 1980; 133: 535, 536.

13. Rush B. Selected writings of Benjamin Rush. Runes D, ed. New York: The Philosophical Library, 1947: 296.

14. Percival T. *Medical ethics* Birmingham, U.K.: Classics of Medicine Library, 1985: 7-10, 9.

15. Picard E. *Legal liability of doctors and hospitals in Canada*. 2nd ed. Toronto/Calgary/Vancouver: Carswell Legal Publishing, 1984: 9, 16-7.

16. Johnston DG. Aeronautics Act and the doctor-patient relationship. *Can Med Assoc J* 1986; 135:1254-6.

17. Locke J. *Two treatises of government*. In: Laslett P, ed. New York, NY/Scarborough, Ont.: New American Library, 1963; 309-10.

18. Englehardt HT. *Foundation of bioethics*. Oxford: Oxford University Press, 1986: 297-301.

19. Kottow MH. Medical confidentiality: an intransigent and absolute obligation. *J Med Ethics* 1986; 12:117-22.

20. Fox DM. From TB to AIDS: value conflict in reporting disease. *Hastings Center Report* 1986; 16:11-23.

21. Moran, Lord. *Winston Churchill: the struggle for survival, 1945-1965*. London: Constable, 1966: xvi; xvii; xvii.

22. Editorial. *Brit Med J* 1966; 1:1313-4.

23. Editorial. *Lancet* 1966; i:920.

24. Gryll H. *Brit Med J* (letter) 1966; 1:1108.

25. General Medical Council. Disciplinary Committee. *Brit Med J* (Suppl. No. 3452): 1971 (20 March): 75-9.

26. Veatch R. *Case studies in medical ethics*. Cambridge, MA: Harvard University Press, 1977: 117.

27. Canadian Medical Association. *Code of Ethics*. Ottawa: The Association, 1984.

28. College of Physicians and Surgeons of Alberta. *Report* 1987 (winter): item 19-1-87.

29. Higgins GL. Confidentiality of medical information: a study of Albertan family physicians. Accepted for publication by *Can Fam Physician* 1988; 34:1301-6.

30. Siegler M. Confidentiality in medicine: a decrepit concept. *New Engl J Med* 1982; 307:1518-21.

31. Kennedy I. Rethinking medical ethics. *J Roy Coll Surg Edin* 1982; 27:1-8.